

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

JOSE AGUIRRE, JR,

No C 06-4030 VRW

Plaintiff,

ORDER

v

MICHAEL J ASTRUE, Commissioner of
Social Security,

Defendant.

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Plaintiff Jose M Aguirre, Jr appeals from the decision of the Social Security Administration (SSA) denying him social security disability benefits. The court now considers cross-motions for summary judgment. Doc #9-1; Doc #10. Because the court concludes that the Administrative Law Judge (ALJ) committed no legal error and his decision was supported by substantial evidence, the court DENIES plaintiff's motion for summary judgment and GRANTS defendant Michael J Astrue's motion for summary judgment.

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I

A

Plaintiff was fifty-nine years old on April 16, 2003, the date he alleges he became disabled. Administrative Record (AR), Doc #6 at 70. Plaintiff is a college graduate. AR 99. Plaintiff has past relevant work experience as a loss prevention agent and as an accounting clerk. AR 94. Plaintiff reported that as a loss prevention agent he used his technical skill and knowledge, counted coins in counting machines, traveled to various locations to check company employees and lifted weights as heavy as fifty pounds occasionally and twenty-five pounds frequently. Id. As an accounting clerk, plaintiff did payroll, light bookkeeping and basic clerical work. AR 564. Plaintiff has not worked since April 16, 2003. AR 70.

The administrative record contains many documents pertaining to plaintiff's respiratory-system concerns. In 1998, plaintiff began consulting Dr Toby Levenson, MD, a board certified allergy and immunology specialist. She noted that plaintiff then had a long history of asthma and that his symptoms included "wheezing, dyspnea on exertion, and cough." AR 175. Dr Levenson also reported that plaintiff had "a history of snoring, but no history of apneic episodes or daytime somnolence." Id. Dr Levenson's letter mentioned normal sinuses and recommended medication for plaintiff's asthma. AR 176.

On April 19, 1999 Dr Levenson noted that plaintiff's cough had completely resolved. AR 169. She also wrote that plaintiff's wife reported to her that plaintiff had had nighttime apneic episodes for two years, during which interval he had gained

1 about fifty pounds. Id. Dr Levenson also wrote that "he does have
2 daytime somnolence and snores at night." Id. Dr Levenson
3 recommended that plaintiff obtain a sleep study to rule out sleep
4 apnea. Id.

5 On July 19, 1999, Dr Levenson reported that plaintiff's
6 full pulmonary function tests revealed only mild obstructive
7 ventillary defect and that plaintiff was "doing well clinically."
8 AR 165. Dr Levenson stated that plaintiff was "awaiting a sleep
9 study to rule out sleep apnea as a contributing medical problem."
10 Id. On September 15, 1999 stated that plaintiff was "doing well,"
11 had "lost 13 lbs," was "sleeping well" and showed no symptoms of
12 asthma or snoring. AR 164.

13 One year later, plaintiff visited Dr Levenson again. AR
14 163. Dr Levenson's clinical notes from September 25, 2000 include
15 a cryptic notation indicating symptoms of sleep apnea. Id. Dr
16 Levenson's notes from a visit the following month, however, do not
17 mention sleep apnea or a sleep study. AR 162. Rather, they
18 indicated that plaintiff was "doing well," that his asthma was
19 "under control" and that he had a "rare cough." Id.

20 Plaintiff visited Dr Levenson again in the spring of
21 2001. Her clinical notes from March 12, 2001 and April 30, 2001,
22 do not mention sleep apnea or a sleep study. AR 161, 160.

23 On June 04, 2001, Dr Levenson noted that plaintiff was "doing
24 well" and was experiencing no problems. AR 159. On December 10,
25 2001, Dr Levenson recorded that plaintiff's asthma had subsided and
26 that plaintiff was "feeling well." AR 157.

27 In addition to his respiratory-system ailments, plaintiff
28 has a history of orthopedic problems. On November 16, 2000,

1 plaintiff underwent arthroscopic knee surgery. AR 381. The
2 procedure demonstrated significant arthritis in the left knee cap
3 and evidence of significant arthritis in the medial compartment of
4 the left knee. AR 258. After the arthroscopy, plaintiff required
5 steroid injection and pain medication. Id.

6 On May 16, 2001, orthopaedic surgeon Dr Daniel Morgan, MD
7 noted that plaintiff had significant degenerative arthritis in the
8 knee, with exposed bone. AR 373.

9 The following year, on July 17, 2002, Dr Morgan stated
10 that plaintiff was experiencing "increasing pain and discomfort in
11 the medial aspect of the knee." AR 260. Dr Morgan obtained x-rays
12 to evaluate the status of plaintiff's knee. Id. The x-rays
13 confirmed that plaintiff had "bone against bone in the medial
14 compartment of the left knee." Id. Plaintiff's right knee had
15 slight narrowing of the medial compartment, not as "severe as that
16 on the left." Id. Dr Morgan administered a steroid injection in
17 the knee. Id. It was plaintiff's first injection in more than two
18 years. Id.

19 Plaintiff visited Dr Morgan again on October 8, 2002.
20 Id. In his notes, Dr Morgan stated that plaintiff was "actually
21 doing well" and that the injection in his knee had helped. Id. Dr
22 Morgan stated that plaintiff did not have significant pain in his
23 knee; however, he did note that plaintiff had some trouble with his
24 shoulder. Id. Dr Morgan administered a steroid injection to
25 plaintiff's shoulder, and noted that plaintiff had "improvement in
26 his symptoms." AR 261.

27 Dr Morgan's February 18, 2003 notes stated that plaintiff
28 had "developed pain and discomfort in the shoulder and also in the

1 biceps region." AR 261. Dr Morgan determined that plaintiff had
2 "gotten gradually more severe," so that he had "difficulty lifting
3 his arm up with his elbow flexed and his arm somewhat forward."
4 Id. Dr Morgan injected him with steroids and stated that plaintiff
5 "had a definite improvement in his symptoms." Id.

6 Plaintiff also consulted cardiologist Dr Rohit Sehgal for
7 heart problems. A March 7, 2003 echocardiogram performed by Dr
8 Sehgal suggested mild diffuse cardiomyopathy (inflamed heart muscle)
9 and mild thickening of the left ventricle of the heart. AR 202.
10 On April 25, 2003, Dr Sehgal performed a left and right
11 catheterization, coronary angiography and ventriculography. AR 191.
12 Plaintiff engaged in exercise and cardio rehabilitation in 2003 and
13 2004. See, e g, 512, 515. A January 28, 2004 echocardiography
14 demonstrated mild to moderate dilated cardiomyopathy. AR 526.

15 In May 2003, plaintiff at last underwent a sleep study
16 with neurologist Dr Stephen Brooks, MD of the Stanford Sleep
17 Disorder Group. AR 145. Dr Brooks's May 13, 2003 Nocturnal
18 Polysomnogram (PSG) Report recorded minimal oxygen saturation
19 levels of 84.8%, consistent with obstructive sleep apnea (OSA). AR
20 145-46. The oxygen saturation levels improved to 94.1% with
21 continuous positive airway pressure (CPAP). Dr Brooks diagnosed
22 OSA, noted that plaintiff improved with CPAP therapy and prescribed
23 a CPAP device. AR 146. "Nasal CPAP is the treatment of choice for
24 most patients with subjective sleepiness * * *. CPAP improves
25 upper airway patency by application of positive pressure to the
26 collapsible upper airway." The Merck Manuals Online Medical
27 Library, "Obstructive Sleep Apnea Syndrome," <<http://www.merck.com/mmpe/sec05/ch061/ch061b.html>> (visited August 16, 2007). On
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1 September 22, 2003, four months after the CPAP device was
2 prescribed, Dr Levenson noted that plaintiff slept comfortably with
3 CPAP therapy. AR 401.

4 Meanwhile, a July 31, 2003 magnetic resonance image
5 (MRI) of plaintiff's right shoulder, requested by treating
6 physician Dr Khalid Baig, revealed continued shoulder problems. Dr
7 Morgan stated that this MRI demonstrated chronic rotator cuff tear
8 and acromioclavicular arthritis. AR 256. Plaintiff informed Dr
9 Morgan that cardio rehabilitation "exercises helped his shoulder"
10 so that he did not feel a need to have any specific aggressive
11 treatment directed to the shoulder. AR 371.

12 On July 8, 2004, Dr Morgan noted that plaintiff's knees
13 caused discomfort when he walked long distances and that plaintiff
14 used a cane in his right hand and a knee brace for support. AR
15 369. On October 20, 2004, Dr Morgan reviewed x-rays taken of
16 plaintiff's left knee. AR 367. Dr Morgan recommended that the
17 plaintiff be evaluated for total knee replacement. Id. On
18 December 27, 2004, plaintiff underwent a minimally invasive mini-
19 incision total knee arthroplasty for his osteoarthritis. AR 293.
20 On February 14, 2005 Dr Morgan noted that plaintiff complained of
21 increased shoulder pain since using a cane following his total knee
22 replacement, AR 358, but plaintiff testified soon afterward that
23 the knee surgery had improved his knee condition. AR 567.

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25 B

26 On April 13, 2003, plaintiff filed an application for
27 Social Security Disability Insurance Benefits. AR 70-72. In the
28 disability report submitted in support of his initial application,

1 plaintiff stated that he was disabled due to his cardiomyopathy,
2 asthma, knee problems, seizures, sleep apnea and shoulder pain. AR
3 93. Both initially and on reconsideration, the SSA denied
4 plaintiff's request for benefits, finding plaintiff not disabled
5 within the meaning of the Social Security Act (Act). AR 27, 33.

6 On September 3, 2003, Dr B Camille Williams, MD, a non-
7 examining State agency physician, opined that plaintiff could lift
8 up to twenty pounds, stand and walk for at least two hours, sit for
9 six hours and push and pull without limitations. AR 239.
10 According to Dr Williams, plaintiff could occasionally climb,
11 kneel, crouch and crawl. AR 240. Plaintiff was limited to "no
12 constant" overhead reaching with his right arm. AR 241.

13 On January 26, 2004, Dr Morgan wrote a letter to the
14 Department of Social Services in response to a request for
15 information regarding plaintiff's medical condition. AR 254. Dr
16 Morgan opined that plaintiff was basically unable to use the right
17 upper extremity for any work-related duties at shoulder level or
18 above and could not lift an object weighing more than four to five
19 pounds to the shoulder level or above. AR 254. Dr Morgan noted
20 that the plaintiff's left knee condition limited his ability to
21 work in any kind of position requiring squatting, stooping,
22 kneeling or any heavy lifting over ten to fifteen pounds. Id. Dr
23 Morgan opined that although the right shoulder and left knee might
24 require future surgical treatment, it was unlikely that plaintiff
25 would return to gainful employment requiring him to be "involved in
26 stooping, squatting, kneeling or nay heavy lifting over ten pounds"
27 with or without surgical treatment. Id.

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1 On March 30, 2004, Dr Harmon Michelson, MD, a non-
2 examining agency physician, completed a residual functional
3 capacity (RFC) assessment concluding that plaintiff could lift up
4 to fifty pounds, stand and walk for two hours, sit six hours and
5 push or pull with limitations in the upper extremities with
6 postural, manipulative and environmental limitations. AR 264-71.

7 On April 28, 2004, plaintiff filed a timely request for
8 an administrative hearing. AR 38. On January 29, 2005 the ALJ
9 sent plaintiff's attorney a pre-hearing letter requesting that
10 plaintiff submit in advance all evidence on which plaintiff would
11 rely. AR 47. The letter also requested a preliminary statement of
12 plaintiff's theory, including plaintiff's position as to which step
13 of the sequential evaluation set forth at 20 CFR 404.1520 (see
14 infra), should be used to decide the case. Id.

15 Plaintiff submitted a pre-hearing brief. AR 134. In the
16 brief, plaintiff asserted that "the combined effect of the
17 claimant's exertional and non-exertional impairments have met or
18 equaled Paragraphs 1.02 (A) and 1.03 of the Listing of
19 Impairments." AR 138. In the alternative, plaintiff argued that
20 the combined effects of plaintiff's impairments precluded plaintiff
21 from "performing his past relevant work, as well as any alternative
22 work." Id. Plaintiff also argued that "using the Medical-
23 Vocational Guidelines (GRIDS) in their framework as a basis for
24 decisionmaking, Rule 201.06 mandates a finding of 'disabled.'" Id.
25 Plaintiff did not make the argument he now makes on appeal -- that
26 the severity of his OSA equals Listing 3.09 because the findings of
27 the PSG test were of equal medical significance to the criteria set
28 forth in the listing.

1 The administrative hearing took place on April 14, 2005.
2 AR 49. At the hearing before the ALJ, plaintiff testified he was
3 unable to work due to his knee pain, shortness of breath,
4 cardiomyopathy, sleep apnea and asthma. AR 565. When asked how
5 long he could stand without a break, plaintiff answered: "I'd say
6 about 10 minutes or so." AR 567. Plaintiff testified that his
7 medication caused headaches two or three times per week, and that
8 it took him "anywhere from 20 to an hour" to sleep off his
9 headaches. AR 573. Plaintiff also testified that he did not use
10 his CPAP machine stating: "when I use it [...] I wake up all of a
11 sudden with my throat very dry, and I tend to gag. I can't swallow
12 right away or I can't breath." AR 572.

13 At the hearing, the ALJ described the plaintiff's residual
14 functional capacity (RFC) to the vocational expert (VE) as:

15 sedentary work, no work at heights, otherwise
16 all postural activities, that is crouch,
17 crawl, kneel, stoop, balance, and use of
18 ramps and stairs, is at occasional, avoid
concentrated exposure to fumes, dust, gases,
and pollens, avoid all hazards as in
hazardous machinery.

19 with the dominant right upper extremity, over
20 head reaching is limited to occasional, and
21 no forceful pushing or pulling [and] as
22 regard to sitting, standing, and walking, an
23 allowance for a one minute stretch break at
least every 30 minutes, standing to stretch
to briefly stand and walk, and I define
briefly standing and walking is up to a
minute.

24 AR 582. The VE opined that a hypothetical individual of plaintiff's
25 age, education and work experience and RFC, as set out by the ALJ,
26 could not work as a loss prevention agent (plaintiff's prior
27 employment), but could work as an accounting clerk if he took one-
28 minute stretch breaks every thirty minutes. AR 582-83. The VE

1 further opined that if plaintiff could not perform the job of
2 accounting clerk, his skills would not be readily transferable to
3 other occupations with the same or lesser degree of skill as his
4 past relevant employment. AR 583-85. In addition, plaintiff would
5 not be able to be employed if he had to alternate sitting and
6 standing every ten minutes and took two to three thirty-minutes naps
7 per day. AR 586-87.

8 On August 17, 2005, the ALJ denied benefits based on the
9 evidence presented at the hearing, including the testimony of
10 plaintiff and the VE, the reports of Drs Baig and Morgan and other
11 medical records. AR 16-23. The ALJ's decision set forth the five-
12 step sequential evaluation of disability required by 20 CFR §
13 404.1520, that is: (1) whether plaintiff was currently engaged in
14 substantial gainful activity; (2) whether plaintiff had a severe
15 impairment or combination of impairments; (3) if plaintiff had a
16 severe impairment, whether plaintiff had a condition that met or
17 equaled any condition detailed in the Listing of Impairments, 20 CFR
18 Part 404, Subpart P, App 1; (4) if plaintiff did not have such a
19 condition, whether plaintiff was capable of performing his past
20 work; and (5) if not, whether plaintiff had the RFC to do other
21 available work.

22 Applying this five-step sequential evaluation to
23 plaintiff, the ALJ found that plaintiff had medically determinable
24 impairments that significantly limited his ability to perform basic
25 work activities, including: cardiomyopathy, osteoarthritis of the
26 left knee post total knee replacement, asthma, sleep apnea, obesity
27 and a chronic right shoulder rotator cuff problem; but that he did
28 not have an impairment that met or equaled any listed impairment.

1 AR 22. He found that plaintiff had the RFC to perform sedentary
2 work with one-minute stretch breaks and other limitations as noted
3 at the hearing. Id. At step four, the ALJ found that plaintiff's
4 impairments did not -- and never had -- precluded the performance of
5 his past relevant work as an accounting clerk. Based on this
6 finding, the ALJ concluded that plaintiff was not disabled at step
7 four and therefore did not proceed to step five. AR 23. He also
8 found plaintiff's subjective statements regarding pain and other
9 symptoms non-credible. Id.

10 The ALJ also noted that plaintiff's own statements to his
11 treating physicians indicated that his symptoms had improved and/or
12 stabilized with treatment. AR 21. In his decision, the ALJ noted
13 that plaintiff reported in July 2003 that he could "walk for 2
14 miles, could drive for an hour, and could do shopping and yard work
15 -- activities which are consistent with my residual functioning
16 capacity finding." AR 21-22. The ALJ concluded, "taking into
17 consideration all of the evidence of record, including the
18 claimant's allegations of pain and other symptoms, that there has
19 been no continuous 12 month period during which claimant has been
20 unable to perform sedentary work with one minute stretch breaks
21 every 30 minutes, and with the other limitations specified []." AR
22 22.

23 In reaching this conclusion, the ALJ also discounted the
24 opinions of treating physicians Dr Baig and Dr Morgan. AR 21. The
25 ALJ concluded that Dr Baig's assessment appeared "to be based
26 largely on claimant's subjective reports of functioning" and that
27 "the medical evidence as a whole did not support the restricted
28 functioning opined by Dr Baig." Id.

While rejecting Dr Morgan's opinion -- that plaintiff could not use his upper extremities to work at or above shoulder level, that he could not lift more than five pounds above shoulder level and could not engage in repetitive stooping, squatting or kneeling -- the ALJ pointed out that neither Dr Morgan's records nor plaintiff's records generally established that plaintiff was "limited for any continuous 12 month period since his alleged disability onset date." AR 20. The ALJ specifically pointed to Dr Morgan's notes documenting plaintiff's ability to "walk with no assistive device within 3 months" of his knee replacement. AR 20-21. The ALJ also pointed to records demonstrating significant relief of plaintiff's shoulder symptoms as a result of steroid injections. AR 21.

II

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The Act provides that certain individuals who are "under a disability" shall receive disability benefits. 42 USC § 423(a)(1)(D). Disability is the "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months." 42 USC § 423(d)(1)(A). An individual will be found disabled if his impairments are such "that he is not only unable to do his previous work but cannot, considering his age, education, and work experience engage in any other kind of substantial gainful work which exists in the national economy * * *." 42 USC § 423(d)(2)(A).

III

Plaintiff makes four major contentions in support of his motion. First, he contends that the ALJ's determination that plaintiff's OSA (Obstructive Sleep Apnea) did not meet or equal the criteria set for in the Listing of Impairments contradicted the clinical studies conducted to determine the presence and degree of the OSA. Doc #9 at 17. Second, plaintiff contends that the ALJ improperly rejected the opinion of plaintiff's treating physician. Dr Baig. Id at 18. Third, plaintiff contends that the ALJ erred by discounting plaintiff's credibility without providing clear and convincing reasons for doing so. Id at 21. Finally, plaintiff contends that the ALJ erred by relying on the VE's answers to incomplete and inaccurate hypothetical questions. The court disagrees with each of these contentions.

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A

Plaintiff alleges presumptive disability under Listing 3.10. Listing 3.10 in its entirety states "Sleep related breathing disorders. Evaluate under 3.09 (chronic cor pulmonae) or 12.02 (organic mental disorders)." Listing 3.09, not much more detailed, is as follows:

Cor pulmonale secondary to chronic pulmonary vascular hypertension. Clinical evidence of cor pulmonale (documented according to 3.00G) with:

A. Mean pulmonary artery pressure greater than 40 mm Hg;

Or

B. Arterial hypoxemia. Evaluate under the criteria in 3.02C2;

Or

C. Evaluate under the applicable criteria in 4.02.

4.02 concerns chronic heart failure. An impairment is medically equivalent to a listed impairment if it is at least equal in severity and duration to the criteria of any listed impairment. 20 CFR § 404.1526. Plaintiff argues that the severity of his OSA equals the listing because the findings from his May 2003 Nocturnal Polysomnogram (PSG) test are at least of equal medical significance to the required criteria contained in Listing 3.09. Doc #11 at 5.

In determining whether a claimant equals a listing under Step 3, the ALJ must adequately explain his evaluation of alternative tests and the combined effects of the impairments. Marcia v Sullivan, 900 F2d 172, 176 (9th Cir 1990).

The ALJ need not state why a claimant failed to satisfy every different section of the listing of impairments. Gonzalez v

1 Sullivan, 914 F2d 1197, 1201 (9th Cir 1990). An examiner's findings
2 should be as comprehensive and analytical as feasible and, where
3 appropriate, should include a statement of subordinate factual
4 foundations on which the ultimate factual conclusions are based, so
5 that a reviewing court may know the basis for the decision. Id.

6 Plaintiff argues that the ALJ's determination improperly
7 fails to give controlling weight to the results of the PSG test from
8 the Stanford Sleep Disorders Group. Doc # 9-1 at 17. During the
9 PSG test, "while breathing unassisted, plaintiff's minimal oxygen
10 saturation was 84.8%," a result consistent with severe OSA. AR
11 479. Plaintiff asserts in his brief that oxygen saturation levels
12 below 90% are considered harmful. Doc #9 at 17. According to the
13 sleep study, with CPAP treatment Plaintiff's oxygen saturation level
14 improved to 94.1%. Id. Plaintiff testified, however, that when he
15 actually started using the CPAP device at home, he had to stop
16 because of dryness in his throat. AR 572. Plaintiff argues that
17 the severity of his OSA equals the Listing because the PSG findings
18 are at least of equal medical significant to the required criteria
19 contained in Listing 3.09/3.10.

20 While the ALJ is required to provide foundations for his
21 equivalency determinations, the ALJ is not required to come up with
22 every potential equivalency scenario on his own. The onus is on the
23 claimant to present a theory of equivalency to the ALJ. In this
24 case, the ALJ requested and received a pre-hearing brief setting
25 forth plaintiff's theory under which he believed he was entitled to
26 benefits. AR 134. Neither in the brief nor at the hearing did
27 plaintiff argue that plaintiff's PSG test results should establish
28 equivalency with Listing 3.10. The ALJ relied on

1 the fact that plaintiff did not undergo the tests required in Parts
2 A and B of Listing 3.09. AR 20. Having failed to offer the PSG
3 test as medically equivalent, plaintiff cannot successfully contend
4 that the ALJ's decision was not supported by substantial evidence.

5 Furthermore, even if plaintiff had asked the ALJ to
6 consider the PSG test results in analyzing equivalency, plaintiff's
7 failure to comply with prescribed treatment might well have vitiated
8 the argument. As previously noted, medical evidence in the record
9 establishes that plaintiff's condition improved with the prescribed
10 CPAP treatment. The social security regulations require that
11 claimants follow prescribed treatment. 20 CFR 404.1530. The
12 regulation states in relevant part:

13 (a) What treatment you must follow. In order
14 to get benefits, you must follow treatment
15 prescribed by your physician if this treatment
can restore your ability to work.

16 (b) When do you not follow prescribed
17 treatment. If you do not follow the
prescribed treatment without a good reason, we
will not find you disabled * * *.

18 20 CFR 404.1530. As a result of the Stanford study, Dr Brooks
19 prescribed plaintiff CPAP therapy going forward. AR 146. The PSG
20 test with the CPAP therapy showed plaintiff's oxygen saturation to
21 be at safe levels. Although plaintiff's complaints of discomfort
22 resulting from the CPAP therapy may be valid, plaintiff has not
23 established that his physician instructed him to discontinue the
24 therapy or that he even discussed the problem with any doctor.
25 Rather, plaintiff glosses over his failure to follow prescribed
26 treatment. Cf 20 CFR § 404.1530(c).

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B

The ALJ properly rejected the opinion of treating physician Dr Baig that plaintiff was unable to perform even sedentary work. AR 556-57. As a general rule, ALJs give the opinions of treating physicians more weight than the opinions of non-treating doctors. Lester v Chater, 81 F3d 821, 830 (9th Cir 1996). Even if the treating doctor's opinion is contradicted by another doctor, the ALJ may not reject this opinion without providing specific and legitimate reasons supported by substantial evidence in the record for so doing. Id.

The ALJ accorded Dr Baig's opinion less than controlling weight based on conflicting medical and other evidence in the record. AR 21. The ALJ noted that while Dr Baig attributed plaintiff's fatigue and poor concentration to cardiomyopathy, echocardiograms showed improvement since 2003. He also explained that: "while Dr Baig suggested in June 2005 that claimant would be unable to perform even sedentary work on a sustained basis due to fatigue and poor concentration, he acknowledged that the claimant's energy level has improved substantially since he last worked." Id. The ALJ concluded that "the medical evidence as a whole does not support the restricted functioning opined by Dr Baig over a sufficient period of time." AR 21.

The court notes, moreover, that in his June 2005 declaration Dr Baig seemed not to know that plaintiff had already stopped using the successful CPAP therapy, as plaintiff testified two months earlier in April 2005. For example, Dr Baig stated "an eight-hour work day * * * would be very difficult for him because his sleep apnea, although helped by the CPAP machine, cannot

1 completely take it away [sic], so he continues to have symptoms of
2 sleep apnea." AR 554. This discrepancy suggests that Dr Baig based
3 his opinion on incomplete information regarding plaintiff's
4 treatment and condition.

5 The ALJ also explained that Dr Baig's assessments appeared
6 to be based on plaintiff's non-credible, subjective reports of
7 functioning. AR 21. See Part III.C, infra.

8 In rejecting the opinion of Dr Morgan (plaintiff's
9 treating orthopedic surgeon) that plaintiff could not use his upper
10 extremities to work at or above shoulder level, that he could not
11 lift more than five pounds above shoulder level and that he could do
12 no repetitive stooping, squatting or kneeling, the ALJ pointed to Dr
13 Morgan's own treatment records. AR 21. Dr Morgan's notes
14 documenting plaintiff's ability to "walk with no assistive device
15 within 3 months" of his knee replacement support the ALJ's decision.
16 AR 20-21. The ALJ also pointed to records demonstrating significant
17 relief of plaintiff's shoulder symptoms as a result of periodic
18 steroid injections. AR 21. The ALJ stated that "Dr Morgan's
19 treatment records indicate that the claimant's shoulder symptoms
20 were recurrent but not persistent." Id. Thus, the ALJ rejected Dr
21 Morgan's "opinion as not well-supported by medically acceptable
22 clinical and laboratory diagnostic techniques, if, in fact, he
23 intended to find the claimant so limited for a period of at least 12
24 months." Id.

25 The ALJ committed no error because he provided specific
26 and legitimate reasons, supported by substantial evidence in the
27 record, for rejecting the opinions of treating physicians Dr Baig
28 and Dr Morgan.

C

Substantial evidence also supports the ALJ's determination that plaintiff's subjective statements regarding disabling symptoms were not fully credible. Once a disability claimant establishes an underlying medical impairment reasonably expected to produce some subjective symptoms, the ALJ may consider various factors in assessing credibility of the allegedly disabling subjective symptoms. 20 CFR § 404.1529. Such factors include, inter alia, type, dosage, effectiveness and adverse side-effects of any medication; treatment, other than medication; functional restrictions; daily activities; and ordinary techniques of credibility evaluation. 20 CFR § 404.1529. If the ALJ's credibility finding is supported by substantial evidence, the courts may not engage in second-guessing. Thomas v Barnhart, 278 F3d 947, 959 (9th Cir 2002).

Here, the ALJ noted that plaintiff's own statements to his treating physicians indicated improvement and/or stabilization of his symptoms. AR 21-22. The record documents such improvement. See AR 186, 340, 395, 401. The ALJ reasoned that plaintiff's statements to his doctors contradicted his own claim of impairments so extreme as to prevent him from doing even sedentary work. AR 22.

The ALJ also cited plaintiff's July 2003 Daily Activities Questionnaire as support for his credibility determination. AR 22. There, plaintiff stated that he could walk for two miles, could drive for an hour, and could do shopping and yard work. AR 108-111. Plaintiff now argues that the statements were merely aspirational and did not accurately reflect his abilities. Doc #11 at 9. Yet, the record supports the ALJ's conclusion.

Considering factors including treatment, functional restrictions, plaintiff's daily activities and inconsistencies in plaintiff's statements, the ALJ properly provided specific, clear and convincing reasons to reject plaintiff's allegations of subjective disabling symptoms. The ALJ's credibility determination must be upheld.

D

The VE's opinions are based on hypothetical assumptions supported in the record and are therefore valid. Having properly rejected the opinions of Drs Baig and Morgan, the ALJ did not err by excluding from the hypothetical question to the VE the functional limitations contained in those opinions. As discussed above, the ALJ properly rejected the opinions of plaintiff's treating physicians.

Plaintiff argues that no examining or consulting physician opined that plaintiff could perform overhead reaching on an "occasional" basis, as the ALJ represented to the VE. The record contains the opinion of non-examining state agency physician Dr Williams, MD. AR 241. Dr Williams stated that based on the review of the medical evidence, plaintiff was limited to "no constant" overhead reaching with his right arm. Id. Dr Williams's opinion therefore supports the assessment of plaintiff's functional limitations presented to the VE.

The ALJ's hypothetical question did not incorporate the opinion of Dr Michelson; however, Dr Michelson's opinion contradicted that of Dr Williams. Resolution of such evidentiary conflicts resides with the ALJ as fact-finder. *Sanchez v Secretary*

1 of Health and Human Services, 812 F2d 509, 511 (9th Cir 1987).
2 Having properly rejected the opinions of Drs Baig, Morgan and
3 Michelson, the ALJ did not err in constructing the hypothetical
4 question consistent with the opinion of Dr Williams. Thus, the
5 testimony of the VE constituted substantial evidence supporting the
6 ALJ's decision.

8 IV

9 For the reasons stated herein, the court affirms the ALJ's
10 decision to deny benefits. Accordingly, the court DENIES
11 plaintiff's motion for summary judgment and GRANTS defendant Michael
12 J Astrue's motion for summary judgment.

13 The clerk is directed to enter judgment in favor of
14 defendant and to close the file.

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16 IT IS SO ORDERED.

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19 VAUGHN R WALKER
20 United States District Chief Judge
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